Lamont Cardon, MD
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Privacy Practices Acknowledgement Form

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient name: _____ Date of Birth: _____

Signature: _____ Today's Date: _____

If reviewed by patient personal representative

Name: _____ Relation to patient: _____

Signature: _____ Today's Date: _____

I request the following person(s) to use or allow disclosure of my health information:
(In addition to patient/patient representative please list any person(s) with which we may disclose/discuss patient information)

☐ Patient family member or friend: _____

☐ Other person: _____

Detailed messages can be left on answering machine

☐ Yes phone number: (_____)_____

☐ No

For office use only *when efforts to obtain acknowledgement of receipt of notice are unsuccessful.*
Good Faith Effort to obtain acknowledgement of Notice Receipt
The above named patient / patient representative was provided with the Notice of Privacy Practices & Efforts to obtain signature on acknowledgement of notice form:
□ *offered copy and the individual accepted delivery & signed form*
□ *offered copy and individual refused to accept delivery & refused to sign form*
□ *Other*